30-10-18. Rates of reimbursement. (a) Rates for existing nursing facilities.

(1) The determination of per diem rates shall be made, at least annually, on the basis of the cost information submitted by the provider and retained for cost auditing. The cost information for each provider shall be compared with other providers that are similar in size, scope of service and other relevant factors to determine the allowable per diem cost.

(2) Per diem rates shall be limited by cost centers, except where there are special level of care facilities approved by the United States department of health and human services. The limits shall be determined by the median in each cost center plus a percentage of the median. The percentage factor applied to the median shall be determined by the secretary.

(A) The cost centers shall be as follows:

(i) administration;

(ii) property;

(iii) room and board; and

(iv) health care.

(B) The property cost center maximum shall consist of the plant operating costs and an adjustment for the real and personal property fees.

(C) The percentile limits shall be determined from an annual array of the most recent historical costs of each provider in the data base.

(3) To establish a per diem rate for each provider, a factor for incentive, historical inflation, and estimated inflation shall be added to the allowable per diem cost.

(4) Resident days in the rate computation.

(A) Each provider which has been in operation for 12 months or longer and has an occupancy rate of less than 85 percent for the cost report period shall have the resident days calculated at the minimum occupancy of 85 percent.

(B) The 85 percent minimum occupancy rule shall be applied to the resident days and costs reported for the 13th month of operation and after. The 85 percent minimum occupancy requirement shall be applied to the interim rate of a new provider unless the provider is allowed to file a projected cost report.

(C) The minimum occupancy rate shall be determined by multiplying the total number of licensed beds by 85 percent. In order to participate in the medicaid/medikan program, each nursing facility provider shall obtain proper certification for all licensed beds.

(D) Each provider with an occupancy rate of 85 percent or greater shall have actual resident days for the cost report period used in the rate computation.

(5) Each provider shall be given a detailed listing of the computation of the rate determined for the provider's facility.

(6) The effective date of the rate for existing providers shall be in accordance with K.A.R. 30-10-19.

(7) Effective January 1, 1994, the case mix payment rate shall be phased in for dates of service through June 30, 1994.

(A) Each provider will receive 50 percent of the rate under the previous system and 50 percent of the rate under the case mix methodology.

(B) Under the case mix methodology, all features of the reimbursement system shall remain with the exception of the health care cost center. The allowance in the health care cost center shall be adjusted by the average case mix index for each facility and based on the resident assessment and classification.

(C) There shall be a "hold harmless" provision for each provider who experiences a rate reduction based on the case mix adjustment for the period from January 1 through June 30, 1994. The rate from the previous payment methodology shall continue if the case mix adjusted rate is less.

(D) Rates shall be adjusted quarterly by the average case mix index for each facility.

(E) Each provider shall be given a detailed listing of the computation of the rate determined for the provider's facility.

(8) Effective July 1, 1994, each provider shall receive rates based strictly on the case mix methodology.

(A) There shall be no "hold harmless" provision.

(B) New limits and rates shall be determined on the basis of cost information submitted by the provider and retained for cost auditing.

(C) Rates shall continue to be adjusted quarterly by the case mix index and applied to the health care cost center for each facility.

(D) Detailed computations of the rate for each facility shall be sent to the provider.

(9) Effective January 1, 1994, resident assessments that cannot be classified shall be assigned to the lowest case mix index.

(b) Comparable service rate limitations.

(1) For each nursing facility and nursing facility for mental health, the per diem rate for care shall not exceed the rate charged for the same type of service to residents not under the medicaid/medikan program.

(2) The agency shall maintain a registry of private pay rates submitted by providers.

(A) Providers shall notify the agency by certified mail of any private pay rate change and the effective date of that change.

(B) The private pay rate registry shall be updated based on the notification from the providers.

(C) The registry shall become effective on the first day of the third month after the regulation is adopted. The providers shall have the same length of time to notify the agency of the provider's private pay rate or the registry shall reflect the last private pay rate on file.

(3) The average private pay rate for comparable services shall be included in the registry. The average private pay rate may

consist of the following variables.

(A) A differential for a private room may be included in the average private pay rate when medicaid/medikan residents are placed in a private room at no extra charge and the private room is not medically necessary.

(B) Extra charges for ancillaries, routine supplies and other items included in the medicaid/medikan rate or payment outside of the rate may be included in the average private pay rate.

(C) If a level of care system is used to determine the average private pay rate, the level of care used to compute the private pay rate shall be that which best characterizes the entire medicaid/medikan population in the facility.

(4) The average private pay rate shall be based on what the provider reasonably expects to receive from the resident. If the private pay charges are consistently higher than what the provider receives from the residents for services, then the average private pay rate for comparable services shall be based on what is actually received from the residents.

(5) When providers are notified of the effective date of the medicaid/medikan rate, the following procedures shall be followed.

(A) If the private pay rate indicated on the agency register is lower, the medicaid/medikan rate, beginning with its effective date, shall be lowered to the private pay rate reflected on the registry.

(B) Providers who subsequently notify the agency by certified mail of the private pay rate shall have the medicaid/medikan rate

adjusted on the first day of the month following the date of the certified letter.

(c) Rate for new construction or new facility to the program.

(1) The per diem rate for newly constructed nursing facilities or a new facility to the medicaid/medikan program shall be based on a projected cost report submitted in accordance with K.A.R. 30-10-17.

(2) No rate shall be paid until a nursing facility financial and statistical report is received and processed to determine a rate.

(d) Change of provider.

(1) The payment rate for the first 12 months of operation shall be based on the rate established from the historical cost data of the previous owner or provider. If the 85 percent minimum occupancy requirement was applied to the previous provider's rate, the 85 percent minimum occupancy requirement shall also be applied to the new provider's rate.

(2) When the care of the residents may be at risk because the per diem rate of the previous provider is not sufficient for the new provider to provide care and services in conformity with applicable state and federal laws, regulations, and quality and safety standards, and the old provider's rate is less than the average statewide rate, the new provider may submit a request in writing to the agency to file a projected cost report. The provisions of this subparagraph shall not apply when capital

improvements, applicable to all providers, are required by new state or federal regulations.

(e) Per diem rate errors.

(1) When the per diem rate, whether based upon projected or historical cost data, is audited by the agency and found to contain an error, a direct cash settlement shall be required between the agency and the provider for the amount of money overpaid or underpaid. If a provider no longer operates a facility with an identified overpayment, the settlement shall be recouped from a facility owned or operated by the same provider or provider corporation unless other arrangements have been made to reimburse the agency. A net settlement may occur when a provider has more than one facility involved in settlements.

(2) The per diem rate for a provider may be increased or decreased as a result of a desk review or audit on the provider's cost reports. Written notice of this per diem rate change and of the audit findings shall be sent to the provider. Retroactive adjustment of the rate paid from a projected cost report shall apply to the same period of time covered by the projected rate.

(3) Each provider shall have 30 days from the date of the audit report cover letter to request an administrative review of an audit adjustment that results in an overpayment or underpayment. The request shall specify the finding or findings that the provider wishes to have reviewed.

(4) An interim settlement, based on a desk review of the historical cost report covering the projected cost report period, may be determined after the provider is notified of the new rate determined from the cost report. The final settlement shall be based on the rate after an audit of the historical cost report.

(5) A new provider that is not allowed to submit a projected cost report for an interim rate shall not be entitled to a retroactive settlement for the first year of operation.

(f) Out-of-state providers. The rate for out-of-state providers certified to participate in the Kansas medicaid/medikan program shall be the rate approved by the agency. Out-of-state providers shall obtain prior authorization by the agency.

(g) Determination of the rate for nursing facility providers re-entering the medicaid program.

(1) The per diem rate for each provider re-entering the medicaid program shall be determined from:

(A) a projected cost report in those cases where the provider has not actively participated in the program by the submission of any current resident service billings to the program for 24 months or more; or

(B) the last historic cost report filed with the agency, if the provider has actively participated in the program during the most recent 24 months. The appropriate historic and estimated inflation factors shall be applied to the per diem rate determined in accordance with this paragraph.

(2) Where the per diem rate for a provider re-entering the program is determined in accordance with paragraph (1)(A) of this subsection, a settlement shall be made in accordance with K.A.R. 30-10-18(e).

(3) Where the per diem rate for a provider re-entering the program is determined in accordance with paragraph (1)(B) of this subsection, a settlement shall be made only on those historic cost reports with fiscal years beginning after the date on which the provider re-entered the program.

(h) The effective date of this regulation shall be September 30, 1994. (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1985; amended May 1, 1986; amended, T-87-29, Nov. 1, 1986; amended May 1, 1987; amended, T-89-5, Jan. 21, 1988; amended Sept. 26, 1988; amended Jan. 2, 1989; amended Jan. 2, 1990; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended Oct. 28, 1991; amended May 1, 1992; amended Nov. 2, 1992; amended Jan. 3, 1994; amended July 1, 1994; amended Sept. 30, 1994.)

JOAN FINNEY, GOVERNOR OF THE STATE OF KANSAS

KANSAS DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES

DONNA WHITEMAN, SECRETARY

December 22, 1994

Mr. Richard P. Brummel
Associate Regional Administrator for the
Division of Medicaid
Room 235, Federal Office Building
601 East 12th Street
Kansas City, Missouri 64106

Dear Mr. Brummel:

In accordance with 42 CFR 447.253, the Kansas Department of Social and Rehabilitation Services submits the following assurances related to Kansas Medicaid payment for long term care services in nursing facilities (NFs) and NFs/Mental Health (NFs-MH). The requirements set forth in paragraphs (b) through (i) of this section are being met. The related information required by section 447.255 of this subpart is furnished herewith and the agency complies with all other requirements.

42 CFR 447.253(f) Findings

The State of Kansas, through this agency does make findings to ensure that the rates used to reimburse providers satisfy the requirements of paragraph 447.253(b).

42 CFR 447.253(b)(1)(i) Payment Rates

The State of Kansas continues to pay nursing facilities (NFs) and NFs-Mental Health (NFs-MH) for long term care services in accordance with a state plan formula established through consultation with representatives of the corresponding provider groups. The rates are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable State and Federal laws, regulations, and quality and safety standards.

42 CFR 447.253(b)(1)(iii) Payment Rates

With respect to NF and NF-MH services, the State of Kansas assures that:

(A) Except for preadmission screening for individuals with mental illness and mental retardation under 42 CFR 483.20(f), the methods and standards used to determine payment rates take into account the cost of complying with Part 483, Subpart B of Chapter IV;

Refers to MS-94-21.

915 SW HARRISON STREET, TOPEKA, KANSAS 66612

OWNER/RELATED PARTY SALARY LIMITATIONS
ALL LEVELS OF CARE
EFFECTIVE 10/01/94

Job Classification	Salary Range	Bed Size: 0-59	60-120	121+	0-99	100	Any Size
Administrator (*)	23E	28,776					
	28E		36,732				
	31E			42,516			
Co-Administrator (*)	19E	23,676					
	22E		27,420				
	24E			30,204			
Accountant (II)	24E						30,204
Attorney (II)	31E						42,516
Bookkeeper	15E						19,488
Secretary (II)	15E						19,488
Gen. Maint. & Repair Tech II	17E						21,480
Physical Plant Supervisor I (1 or 2 Facilities)	23E						28,776
Physical Plant Superivsor II (3 or More Facilities)	25E						31,728
Cook	11E						16,032
Food Service Supervisor II	17E						21,480
Housekeeper/Laundry Worker	9E						14,544
Director of Nursing (RN III *)	25E				31,728		
Director of Nursing (RN IV *)	28E					36,732	
Registered Nurse (RN II *)	22E						27,420
Licensed Practical Nurse (LPN *)	18E						22,548
LPN Supervisor (*)	20E						24,876
Health Care Assistant (Nurse Aides)	12E						16,860
Mental Health Aide	12E						16,860
Physical Therapist II (*)	27E						34,968
Physical Therapist Aide	13E						17,688
Occupational Therapist II (*)	26E						33,324
Speech Path./Audio. I. (*)	26E						33,324
Activity Therapy Tech.	14E						18,564
Activity Therapist I (*)	22E						27,420
Social Worker (*)	22E						27,420
Medical Records Administrator	24E						30,204
Medical Records Technition	19E						23,676
Central Office (3 or More Facilities)							
Chief Executive Officer	36E						54,264
Chief Operating Officer	34E						49,248
All Other Chief Officers	31E						42,516

(*) License/Registration/Certificate Requirement

JOAN FINNEY, GOVERNOR OF THE STATE OF KANSAS

KANSAS DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES

DONNA WHITEMAN, SECRETARY

December 22, 1994

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Associate Regional Administrator for the
Division of Medicaid
Room 235, Federal Office Building
601 East 12th Street
Kansas City, Missouri 64106

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In accordance with 42 CFR 447.253, the Kansas Department of Social and Rehabilitation Services submits the following assurances related to Kansas Medicaid payment for long term care services in nursing facilities (NFs) and NFs/Mental Health (NFs-MH). The requirements set forth in paragraphs (b) through (i) of this section are being met. The related information required by section 447.255 of this subpart is furnished herewith and the agency complies with all other requirements.

42 CFR 447.253(f) Findings

The State of Kansas, through this agency does make findings to ensure that the rates used to reimburse providers satisfy the requirements of paragraph 447.253(b).

42 CFR 447.253(b)(1)(i) Payment Rates

The State of Kansas continues to pay nursing facilities (NFs) and NFs-Mental Health (NFs-MH) for long term care services in accordance with a state plan formula established through consultation with representatives of the corresponding provider groups. The rates are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable State and Federal laws, regulations, and quality and safety standards.

42 CFR 447.253(b)(1)(iii) Payment Rates

With respect to NF and NF-MH services, the State of Kansas assures that:

(A) Except for preadmission screening for individuals with mental illness and mental retardation under 42 CFR 483.20(f), the methods and standards used to determine payment rates take into account the cost of complying with Part 483, Subpart B of Chapter IV;

Refers to MS-94-21.

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(B) The methods and standards used to determine payment rates provide for an appropriate reduction to take into account the lower costs (if any) of the facility for nursing care under a waiver of the requirement in 42 CFR 483.30(c) of Chapter IV to provide licensed nurses on a 24-hour bases;

(C) The State of Kansas established procedures under which the data and methodology used in establishing payment rates are made available to the public.

42 CFR 447.253(b)(2) Upper Payment Limits

The State of Kansas assures that the estimated average proposed Medicaid payment is reasonably expected to pay no more in the aggregate for NF and NF-MH services than the amount the agency reasonably estimates would be paid under the Medicare principles of reimbursement. There are no state operated NFs or NFs-MH so 447.272(b) does not apply.

42 CFR 447.253(d) Changes in Ownership of NFs and ICFs-MR

The State of Kansas assures that its NFs and NFs-MH payment methodology is not reasonably expected to result in an increase in aggregate payments based solely as the result of a change in ownership in excess of the increase that would result from application of 447.253(d)(1) and (2).

42 CFR 447.253(e) Provider Appeals

The State of Kansas, in accordance with federal regulations and with the Kansas Administrative Regulations, provides a fair hearing, appeal or exception procedure that allows for an administrative review and appeal by the provider as to their payment rates.

42 CFR 447.253(f) Uniform Cost Reporting

Nursing facilities and NFs-MH providers are required to file annual uniform cost reports in accordance with Kansas Administrative Regulations and Attachment 4.19D, Part I, Methods and Standards for Establishing Payment Rates.

42 CFR 447.253(g) Audit Requirements

The State of Kansas performs a review on all cost reports within six months of receipt and provides for periodic field audits of the financial and statistical records of the participating providers.

42 CFR 447.253(h) Public Notice

In accordance with 42 CFR 447.205, public notice is given for the significant changes proposed to the methods and standards for setting NF and NF-MH payment rates.

Refers to MS-94-21.

42 CFR 447.253(i) Rates Paid

The State of Kansas assures that payment rates are determined in accordance with methods and standards specified in an approved State Plan.

42 CFR 447.255 Related Information

Estimated Average NF/NF-MH Rate:	10/1/94	$60.08
Estimated Average NF/NF-MH Rate:	7/1/94	$60.08
Per Diem Increase		0
Average Percent Increase		0%

Both the short-term and long-term effect of these changes are estimated to:

1. Maintain the availability of services on a statewide and geographic area basis.

   There are approximately 407 licensed NFs or NFs-MH in the State of Kansas with at least one in every county. Of these, 399 or 98% are certified to participate in the Medicaid Program. There are 16 licensed NFs-MH in the State of Kansas and all of them participate in the Medicaid program. Beds are available in every area of the State and close coordination with the local and area SRS offices allows the agency to keep close track of vacancies;

2. Maintain the type of care furnished; and

3. Maintain the extent of provider participation.

   The extent of provider participation should not be affected by this change. Ninety-five percent of the available providers are already participating in the program.

Any questions regarding this Plan submission should be directed to Tina Hayes or Bill McDaniel at (913) 296-3981.

Sincerely,

Donna L. Whiteman
Secretary

DLW:RLE:TAH:mas

Refers to MS-94-21